

ternal layers, while new connective tissue layers are placed on the inner surface." Virchow speaks very decidedly on the subject in the following extract which Dr. Keen has translated for me from the work on "Morbid Tumours :"—

"They are most frequent as small osteomata on the free surface of the choroid. They are mostly flat bones, which seem to lie on the vascular tunic, or to have taken the place of the retina, and therefore have often been described as ossifications of the retina. They generally lie in the posterior part of the eye; sometimes, however, stretching quite far forwards. They consist of good, firm, osseous tissue, moderately rich in vessels, proceeding, as a rule, from connective tissue, but sometimes from cartilage. That they are the result of chronic choroiditis is certain."

From their position next the choroid, and from the great difficulty, in many cases, of detecting any traces of the retina, it is not surprising that these formations have often been mistaken for ossifications of the retina; and, indeed, Stellwag says, that when any part of the degenerated retina remains in contact with the bony plate, it also becomes bony. If new layers of connective tissue are formed on the inner surface after the outer layers are ossified, it would seem that these bony plates are capable of independent growth. As they are among the recognized causes of sympathetic ophthalmia, it is worth while to bear in mind the possibility of their presence in deciding upon the operation to be performed. It is evident that not much could have been accomplished in either of these cases by any operation less thorough than that of extirpation of the globe. An interesting point in the history of the first case is the fact, that nearly thirty years intervened between the inflammation that destroyed the sight of the left eye and the appearance of sympathetic irritation of the right.

*Suppression of the Urine; Jaundice.*—Dr. HUTCHINSON presented the liver and kidneys of a man, æt. 40, who died in the Pennsylvania Hospital March 7, 1870. The following points of his history are of especial interest in connection with the disease of which he died: In the year 1860 he contracted gonorrhœa, which did not yield very readily to treatment, and seems to have given rise to a stricture of the urethra; for, on several occasions during the last seven years, catheterization has been resorted to to relieve his bladder of its contents. He has lived a roving life, but has never been excessively intemperate, nor has he ever had a chancre. On the 23d of February he found he was unable to pass his water, but does not appear to have sought medical assistance until the next day. It is not known whether or not the physician applied to succeeded in introducing a catheter into his bladder; but as no relief was obtained, he applied for and gained admission into the surgical wards of the Pennsylvania Hospital on the evening of February 24th. No difficulty was experienced in passing a catheter into the bladder; but as no urine flowed through it, percussion was performed over the hypogastric region, and the bladder found to be empty. Twelve hours later, ten fluidounces of a very dark-coloured liquid, which contained albumen, and under the microscope a large number of red blood corpuscles were passed naturally and without difficulty. The next evening jaundice supervened.

*Feb. 27.* The patient was transferred to the medical wards, and the following is from the notes taken at that time: "No urine has been passed since that above alluded to; percussion over the region of the bladder still gives a clear sound; the pulse is 82; the respirations

slightly more frequent than in health; the tongue is covered with a dry and brownish coating; the teeth are incrustated with sordes; tenderness in the region of the gall-bladder; no increase or diminution of hepatic dulness; tympanitic resonance over abdomen. Patient is excessively restless, and throws himself about in bed while answering questions; he answers questions intelligently; complains of excessive thirst."

The treatment adopted consisted in the administration of diuretics and anodynes. The next day a small quantity of urine (not more than fʒij) was passed. This was found to contain albumen, but did not show the presence of biliary colouring matter when tested with nitric acid. A systolic murmur was heard at base of heart to left of sternum. The patient not having had a passage from his bowels since he left the surgical ward, was ordered an injection, which brought away a large quantity of feces, which were not light-coloured. On the first of March three more ounces of urine were passed; incontrollable vomiting and hiccough were added to the other symptoms. A few observations of the temperature of the surface showed that this was low: the thermometer in the axilla on two occasions indicating 95°, and on another 97° Fahr.

The symptoms above detailed, with the exception of the secretion of urine, which became quite free on March 4th, gradually increased in severity, the vomiting being unchecked by all the remedies employed. Diarrhœa also supervened, so that the nutritious enemata, with which an attempt was made to nourish the patient, were rejected. There was at no time somnolence or tendency to stupor. The patient sank from asthenia on the morning of March 7th.

The autopsy was made the next day, twenty-four hours after death. The body was emaciated and the skin jaundiced; the head not examined. Chest: Lungs somewhat engorged at their posterior and lower parts, but were otherwise healthy; no pleural adhesions or effusion. The heart was healthy, with the exception of slight thickening of the mitral valves. Abdomen: Liver enlarged, engorged with blood, and deeply stained with bile; gall-bladder filled with viscid bile; kidneys enlarged, of a pale-yellow colour, presenting the gross appearances of chronic tubular nephritis. A stricture of the urethra was found in its membranous portion, and an abscess in one of the lobes of the prostate gland.

The microscopic examination was made by Dr. J. G. RICHARDSON, who found the evidences of the first stage of tubular nephritis. The straight portions of many tubes were choked with granular matter, which prevented the descent of the urine.

Dr. PEPPER said this case suggested to him that of a soldier belonging to one of the regiments passing through the city during the late war. He had a stricture of the urethra, and on reaching this city was seized with retention of urine. A physician practised forcible catheterization on a Sunday afternoon. This was followed by vomiting and complete suppression of urine. The medical man kept him at his house during the night, and on the next morning brought him in his carriage to the Pennsylvania Hospital. In a very short time he became intensely jaundiced, with symptoms leading to the diagnosis of an abscess of the liver. He remained in this condition, apparently dying, for two weeks, when he began to expectorate a purulent matter, which did not respond to Pettenkoffer's test, though it was thought to come from an hepatic abscess, which had discharged through the lungs. He slowly gained strength, and insisted upon proceeding homewards, although still very ill.